CODE	Section VIII APPLICATIONS AND ENROLLMENT **Standard of 95 percent relates to requirements of timeliness, accuracy, and disclosure.**	YES	NO	NOTE
	ELIGIBILITY TO ENROLL **Use Worksheets: WS-EN2**			
EN01	**The MCO does not deny enrollment on the basis of health status except for ESRD or hospice care election in a Medicare-certified hospice (unless subject to 42 CFR 417.432 conversions). 42 CFR 417.422(a), (b) and (c); HMO Manual § 2003.1** **[ ] MET [ ] NOT MET**			
MOE	Regarding denial of enrollment and health screening, determine if the enrollment process includes procedures for assessing and verifying reasons for denial, and require the appropriate documentation supporting such denial. **Review:** ❑ Internal written policies and procedures; ❑ language in applications; ❑ complaint/grievance logs; ❑ routinely used enrollee correspondence; ❑ correspondence regarding enrollment or denial of enrollment; ❑ materials used for pre-enrollment seminars, and samples selected. **Interview:** Staff responsible for: ❑ processing Medicare applications; ❑ working with applicants prior to enrollment; and ❑ sending enrollment information.			
	APPLICATION FORMS **Use Worksheets: WS-EN1 and WS-EN2**			
EN02	**Applications are signed and dated by the enrollee.** **42 CFR 417.430(a); HMO Manual § 2001.5**(c) **[ ] MET [ ] NOT MET**			
EN02a	The HMO has documentation to establish that an applicant other than a beneficiary is authorized under state law to make decisions related to health insurance election. OPL 95.007			
EN03	**Applications or acceptable facsimiles are on file for all current enrollees and are kept for at least 1 year following an enrollee's disenrollment.** **42 CFR 417.430(a)(2); HMO Manual § 2001.5(C), OPL 95.015** **[ ] MET [ ] NOT MET**			
EN04	**Applicants are given an opportunity to acknowledge that they understand the MCO's rules and agree to abide by them.** **42 CFR 417.422 (e) HMO Manual § 2001.5(c)** **[ ] MET [ ] NOT MET**			

EN05	**Applicants are informed (through the application process, pre-enrollment marketing information, and in the evidence of coverage) that their enrollment will result in disenrollment from another MCO's Medicare product if they are currently enrolled in another MCO.** **42 CFR 417.422; HMO Manual § 2001.5(c)** **[ ] MET [ ] NOT MET**			
MOE	See the National Marketing Guidelines for Evidence of Coverage (EOC) requirements. An EOC may also be known as a member contract, a subscriber agreement, or a certificate of coverage. Verify that (1) the appropriate person has signed the application; (2) if someone other than the beneficiary has executed, signed and dated the application, then verify under state law that the applicant is authorized to make decisions related to health insurance election; (3) that the MCO checked the authorized signatory's authority and obtained substantiating documentation. **Review:** ❑ Internal procedures and documentation accompanying the application. ❑ Procedures manual and files where applications are kept. ❑ Review statement of understanding and/or verification script, if the plan utilizes these documents. **Determine:** ❑ If procedures require that applications be maintained for 1 year past disenrollment. **Interview:** ❑ Administrative staff responsible for files; and / or marketing or administrative personnel/manager.			
	ENROLLMENT PROCEDURES **Use Worksheets: WS-EN1; WS-EN2, WS-EN-3**			
EN06	**The MCO has an effective system in place for receiving, controlling, and processing applications from Medicare enrollees. Applications are dated as of the date they are received by the MCO. Applications are processed in chronological order by date of receipt.** **42 CFR 417.430(b), (b)(1) and (b)(2); HMO Manual § 2001.6** **[ ] MET [ ] NOT MET**			
EN07	**The MCO notifies the applicant in writing of the receipt and/or denial if appropriate, prior to processing the application and no later than 30 days following receipt of the application. The written notice of receipt specifies the proposed effective date of enrollment, or, if the MCO is currently enrolled to capacity, explains the procedures that will be followed when vacancies occur.** **42 CFR 417.430(b)(3);(b)(4)(I)and (ii); HMO Manual 2001.6** **[ ] MET [ ] NOT MET**			
EN08	**The MCO provides the applicant with a signed and dated copy of the application form.** **HMO Manual § 2001.6**			

EN09	**The MCO transmits the applicant's enrollment information to HCFA within 30 days from the date from the receipt of the application or from the date a vacancy occurs if the latter is due to capacity restrictions (or, within an additional period of time approved by and HCFA).** **42 CFR 417.430(b)(6); HMO Manual § 2001.7 [ ] MET [ ] NOT MET**			
EN10	**If the application is denied prior to submission to HCFA, within 30 days of MCO receipt of a signed application, the MCO provides the applicant with a written explanation of the reason for the denial.** **42 CFR 417.430(b)(5); HMO Manual § 2001.6 [ ] MET [ ] NOT MET**			
EN11	**When the MCO receives enrollment confirmation from HCFA, it promptly (within 14-30 days) notifies enrollees in writing of the effective date of enrollment, and sends the member a HCFA-approved evidence of coverage that describes MCO rules, including benefits and enrollee rights and responsibilities.** **42 CFR 417.430(b)(7) and 42 CFR 417.436(b); HMO Manual § 2001.5B; National Marketing Guidelines** **[ ] MET [ ] NOT MET**			
EN12	**When the MCO is filled to capacity or closes enrollment following at least a 30-day open enrollment period, it notifies subsequent applicants in writing of the procedures that will be followed when enrollment reopens or vacancies occur. The procedures ensure that vacancies are filled in chronological order.** **42 CFR 417.430(b)(8); HMO Manual § 2001.3 [ ] MET [ ] NOT MET**			
EN13	**The MCO adheres to the requirements in requesting retroactive enrollments from the HCFA Regional Office.** **HMO Manual § 2002**			
MOE	**NOTE TO REVIEWER:** In order for EN06 to be Met, elements EN07 through EN13 must be met. ❑ Determine if the MCO adequately controls the Medicare application process, including: date stamping the application upon receipt; directing the application to the appropriate processing department for completeness review; notifying applicants accurately regarding receipt of the application and the proposed effective date and/or denial of the application; and the submission of accretions to HCFA in a timely manner (within 30 days). Applicants are advised in writing, and in a timely manner, regarding the reason for denial if he or she fails to meet regulatory requirements for enrollment. ❑ Determine if there are procedures for reviewing and taking appropriate follow-up action in response to *HCFA Monthly Transaction Replies/Monthly Activity Report* listings (e.g., applicants enrolled are promptly (within 14-30 days) notified in writing of effective date of enrollment and provided information on enrollee rights, responsibilities, and benefits; denied applicants are informed of reason for denial). If the MCO-submitted data are determined by HCFA to be in error, then internal records are corrected and resubmitted to HCFA.			

MOE con't.	❑ Determine if the MCO reviews the monthly *HCFA Monthly Transaction Replies/Monthly Activity Report* listings upon receipt, and takes appropriate action in response to status reports on accretion actions. This assessment is based in large part upon on-going interaction with MCO's staff. If enrollment is closed, the MCO notifies the applicants in accordance with HCFA requirements, and there is a process in place to wait-list applicants and enroll them on a first-come, first-served basis. Cross reference EN11 w/MB05 ❑ The MCO maintains copies of denied applications in a separate file for at least one year following the date of application in order to provide HCFA with units of analysis. (Note: sample used in WS-EN2 (Denial of Enrollment). ❑ Determine if staff involved in processing Medicare applications are properly trained and have accurate/up-to-date manuals. **Review:** ❑Internal procedural manuals; ❑correspondence to applicants and enrollees; ❑tapes submitted to HCFA, ❑ internal systems records of enrollments, ❑ sample of active and denied applications. Reconcile MCO records against HCFA records. **Interview:** *At the discretion of the reviewer*, staff responsible for processing Medicare applications; and/or staff who work with applicants prior to and during the enrollment process; and/or staff who input and review HCFA enrollment information and send out membership information to new enrollees.			
EN14	**The MCO accepts as a Medicare enrollee any individual who applies and is enrolled in the MCO during the month immediately before the month of entitlement to Medicare Parts A and B, or Part B only. 42 CFR 417.432; HMO Manual § 2003.5** **[ ] MET [ ] NOT MET**			
	EMPLOYER GROUP APPLICANTS AND ENROLLEES **Use Worksheets:WS-EN4** **(NOTE:** Most of these requirements are based on regulations which apply to enrollment and applications in general.)			
EN15	**RISK MCOs ONLY (Retroactive enrollment only): The MCO enrolls Medicare Employer Group Health Plan (EGHP) applicants who are enrollees of an employer group plan which certifies that it provided him/her with an explanation of enrollee rights, including the lock-in requirements.** **§ 4204(e) OBRA 1990; HMO Manual § 2002** **[ ] MET [ ] NOT MET**			
EN16	**The MCO does not exceed the limitation (up to 90 days) which allows HCFA to retroactively adjust Medicare payments to the MCO to cover the period of time the applicant enrolls through the EGHP and becomes eligible to receive services under the risk contract, and the time the application is received by the MCO and transmitted to HCFA.** **§ 4204(e) OBRA 1990; HMO Manual § 2002** **[ ] MET [ ] NOT MET**			

EN17	**For "working aged" MCO enrollees who are employed by groups which are subject to Medicare Secondary Payer regulations, the MCO only offers premium waiver (or premium reduction) if the enrollee maintains coverage through <u>both</u> the TEFRA risk and/or cost product and the group product.** **§ 4204(g)(1)(C) OBRA 1990; HCFA Program Updates, October 11, and October 20, 1994. [ ] MET [ ] NOT MET**			
MOE	**<u>Review/Determine</u>:** Employer group contracts; EGHP member applications; internal procedural manuals: ❑ For retroactively enrolled group applicants, assure that (1)a lock-in statement is obtained and (2) signed prior to the effective date of enrollment., and (3) applicants are not enrolled any more than 3 months retroactively. ❑ Assure that applications are processed timely and applicants are informed of their effective enrollment date. ❑ Assure that contractual agreements or other arrangements contain language which ensures that the employer group will cooperate with the MCO to assist in meeting the regulatory requirements for EGHP. ❑ Does the MCO ensure that those applicants who live within the MCO's state-approved service area, but whose residence is not within the Medicare approved geographic area, are not denied the opportunity to enroll, and informed of limitations in seeking care from Medicare geographic area providers? ❑ Related correspondence in enrollee files. **<u>Interview:</u>** Staff responsible for developing materials/application for EGHP enrollees. **<u>Working aged enrollees employed with groups of 20 or more employees</u>:** Per Instructions to Industry Memorandum, dated January 11, 1994, risk-based contracting MCOs are responsible for identifying and reporting working aged members beginning January 1, 1995. The minimum requirements are: ❑ a questionnaire to all new members, ❑ an annual questionnaire to all beneficiaries, ❑ biannual advertisement through newsletter or other means, ❑ verification upon receipt of HCFA data, i.e., from the Common Working File (CWF), and ❑ incorporation of a working aged identifier in the coordination of benefits (COB) activities. **<u>Working aged enrollees employed with groups of less than 20 employees:</u>** This requirement (see EN-17) does not prohibit the small group employer from entering into an agreement with the MCO to retain benefits for such "working aged" employees under the group (commercial) product and informing Medicare-eligible employees of this option. **<u>Interview:</u>** Staff responsible for systems and procedures for working with employer groups relative to membership activity, for processing EGHP-member applications, and for directing and controlling correspondence to them.			